WELCOME

The information in this confidential personal history form is critical to the evaluation of your vision

❑ Mr. ❑Mrs. ❑Ms. ❑Miss ❑Dr. ❑Reverend

Patient History: Name_____

Date_____

Address_____ City_____

ZIP_____

Home Phone (_____) _____Social Security #_____

Employer_____ Work Phone (_____) _____ Ext. _____

Person Responsible for account _____ Date of Birth _____

Please show us all of your insurance cards so that we may properly submit to your insurance.

Date of your last eye examination_____ Have you ever had vision therapy? ❑ Yes ❑ No

Do you wear glasses now? ❑Yes ❑No Have you ever worn glasses? ❑Yes ❑No

What do you wear glasses for? ❑Distance only ❑Near only ❑Wear full time ❑Computer monitor

Do you wear contact lenses at this time? ❑Yes ❑No What type? _____

Have you had problems wearing contacts? ❑Yes ❑No Have you been told you cannot wear them? ❑Yes ❑No

Please explain what happened_____

Are you interested in trying contacts? ❑Yes ❑No

What is your main reason for coming here today?

_____

_____

Are you interested in vision improvement? ❑ Refractive Surgery ❑ Laser Correction ❑Vision

HEALTH HISTORY: Please check the conditions that apply to you and your family.

	Yes	No	Family
EYES			
Lazy or turned eye	❑	❑	❑
Color "blind"	❑	❑	❑
Light sensitive	❑	❑	❑
Eyestrain	❑	❑	❑
Dry eyes	❑	❑	❑
Excess tearing	❑	❑	❑
Itching/ burning	❑	❑	❑
Floaters ❑	❑	❑	
Flashes of light	❑	❑	❑
Retinal detachment	❑	❑	❑
Macular degeneration	❑	❑	❑
Cataracts	❑	❑	❑
Glaucoma	❑	❑	❑
Eye surgery or Injury	❑	❑	❑
EAR, NOSE, THROAT			
Allergies	❑	❑	❑
Sinus congestion	❑	❑	❑
Dry throat/mouth	❑	❑	❑

	Yes	No	Family
VASCULAR			
Diabetes	❑	❑	❑
High Blood Pressure	❑	❑	❑
Vascular disease	❑	❑	❑
RESPIRATORY			
Asthma	❑	❑	❑
Emphysema	❑	❑	❑
GASTROINTESTINAL	❑	❑	❑
GENITOURINARY ❑	❑	❑	
BONE, JOINT, MUSCLE			
Rheumatoid Arthritis	❑	❑	❑
Muscle or joint pain ❑	❑	❑	
LYMPHATIC, HEMATOLOGIC			
Anemia	❑	❑	❑
ENDOCRINE (thyroid/ glands)	❑	❑	❑
PSYCHIATRIC	❑	❑	❑
INTEGUMENTARY (skin)	❑	❑	❑
NEUROLOGIC			
Headaches, migraines	❑	❑	❑

Who is your general physician? _____Date of last physical _____

Please list your current medications _____

What conditions do you take these for?

_____

Are you allergic to any Medicines? Please list_____

Any history of cancer, heart attack, stroke, other? List & tell treatment_____

SOCIAL HISTORY:

Do you use tobacco? ❑Yes ❑No What type and how often? _____

Do you drink alcohol? ❑Yes ❑No What type and how often?_____

Have you been exposed to or infected with: ❑Gonorrhea ❑Syphilis ❑Hepatitis ❑HIV

PLEASE FILL IN BOTH SIDES OF THIS FORM AS COMPLETELY AS POSSIBLE

OCCUPATION: What kind of work do you do? _____

What activities do you do at work: ***(Circle all that apply)*** driving typing data entry computers program inspecting accounting writing/editing using spread-sheets loading deliveries sales monitor instruments.

Do you use a computer on your job? . . . . ❑ **Yes** ❑ **No** # hours daily _____

Do you use a computer at home? . . . . . ❑ **Yes** ❑ **No** # hours daily _____

What lenses do you wear? . . . . . ❑ **None** ❑ **glasses** ❑ **bifocals** ❑ **contacts**

When computing, do your eyes get . . . . ❑ **red** ❑ **dry** ❑ **ache** ❑ **Sore**

Do you feel pain or discomfort in your. . . ❑ **neck** ❑ **back** ❑ **shoulder**

Do letters ever seem to "swim"? . . . . . ❑ **Yes** ❑ **No**

Does office lighting bother you? . . . . . ❑ **Yes** ❑ **No**

Do reflections and glare bother you? . . . ❑ **Yes** ❑ **No**

Is it hard to proof-read, or find errors?. . . ❑ **Yes** ❑ **No**

Do you experience any of the following discomforts at work or at home (after or during near work)?

❑ Headaches? ❑ Letters blur as you read? ❑ Occasionally see double?

❑ Eyestrain? ❑ Eyes red or watery? ❑ Pulling sensation near eyes?

❑ Get sleepy? ❑ Lose your place often/ skip words? ❑ Do you avoid certain tasks?

❑ Does it take more and more effort to see clearly as the day wears on?

❑ Do you avoid reading after work, but read on weekends? How long can you read?_____

❑ Do you "hunch" closer to your work as the day wears on?

❑ Do street signs ever seem blurred as you drive home from work?

❑ Is it ever difficult to bring print or objects to clear focus? When_____

RECREATION AND LEISURE:

In what recreational activities do you participate? (*Circle* all that apply) read racquetball tennis golf baseball basketball swim camp sew play cards flying video games musical instrument

Other recreational activities_____

Do you wear any special or protective eyewear for your sport? ❑ **Yes** ❑ **No**

Does your vision, or do your lenses, interfere with any activity? ❑ **Yes** ❑ **No**

What are you doing to protect your eyes from ultraviolet exposure?_____

Do you currently wear glasses that have an anti-reflective coating? ❑ **Yes** ❑ **No**

Television: is viewing ever uncomfortable? Please describe your discomfort:_____

Do you ever experience car or motion sickness? ❑ **Yes** ❑ **No**

VERY IMPORTANT! ***NEW PATIENTS:*** *WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?*

*Name of friend, relative, or doctor*_____ If not referred, how did you choose our office for your visual needs? Please check the appropriate answer: ❑Sign/Building **INTERNET:** ❑Facebook ❑ Website ❑ YouTube ❑Other_____

INSURANCE AND PAYMENT POLICIES

Our office provides a trained insurance manager to assist in filing your insurance. With your permission we keep your signature on file to process your claims.

Payment for services is required at the time of your visit, unless prior arrangements have been made. Payment of half is due to order your custom glasses or contacts and the balance is due upon pick up. After ninety days in default of payment, you agree to pay the collection fees as permitted by state law.

❑Yes _____ (Signature authorization for insurance & collection)